Chapter 2

Assessment and Diagnosis of PTSD in Adults: A Comprehensive Psychological Approach

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INTRODUCTION

The assessment of post-traumatic stress disorder (PTSD) is the focus of an increasingly large body of literature. At least four books (Briere, 1997; Carlson, 1997; Stamm, 1996; Wilson and Keane, 1997) and numerous chapters and journal articles have been devoted to various aspects of the subject appearing within the past few years alone. The aim of this chapter is to give an overview of a comprehensive psychological approach to the assessment and diagnosis of PTSD in adults. In the first section, we begin with a discussion of the distinction between the limited goal of establishing a diagnosis and the aim of assessing PTSD from the standpoint of a functional approach to clinical evaluation. We believe that the latter yields a more useful account, in that patients' interpretations of, and adaptations to, a traumatic event are explored within the context of their psychosocial development across the life span. Valid clinical assessment also requires a sensitivity to the possibility of temporal instability in PTSD symptoms and the current level of functioning at which patients present for evaluation since this disorder, similar to other forms of severe psychopathology, has variable manifestations over time.

The next two sections of this chapter contain descriptions of some specific methods that the clinician can use to evaluate PTSD within the life span, contextualized manner that we advocate. These include a trauma-focused psychosocial history, as well as the structured clinical interviews and psychometric instruments that have been developed specifically for assessing PTSD and commonly associated conditions. In addition, we provide

suggestions about screening for PTSD in situations in which limitations of time and resources preclude a more comprehensive evaluation.

In the third section, we describe how the results of such an evaluation can be used in planning for treatments. Here we discuss the controversial issue of when, or even whether, treatment should be focused on memories of traumatic events and the symptoms associated with those memories.

DIAGNOSIS VERSUS ASSESSMENT

Unfortunately, simply making a diagnosis of PTSD yields incomplete information to the clinician. There are a number of reasons why this is the case. First, a diagnosis of PTSD alone does not lead to straightforward decisions about treatment. Second, PTSD is a complex condition that typically has a deleterious impact on multiple areas of psychosocial functioning. Therefore, the information conveyed by a diagnosis of PTSD says little about the other areas of patients' lives that may be adversely affected by, or interact with, the condition. Third, the criteria for making a diagnosis of PTSD have changed over the relatively brief period of time during which it has been included in the standard nosology (American Psychiatric Association, 1980; 1994). The results of at least one recent empirical investigation (e.g., King et al., in press) even call into question whether PTSD is a single, coherent disorder or, alternatively, a superordinate category subsuming two or more distinct clinical conditions. Thus, the diagnosis by itself may mask important distinctions that, when taken into account, make possible a more comprehensive, detailed, and idiographic understanding of the disorder as it is manifested by different patients. In short, a diagnosis of PTSD, important though it may be, cannot stand alone. In our view, post-traumatic adjustment must be understood with respect to the development of the afflicted patient over his or her life course. This entails a comprehensive assessment, in which the diagnosis of the disorder is but one part of the process of clinical evaluation.

We recommend that traumatized individuals be evaluated within a life span, contextual approach to clinical assessment. Although beyond the scope of this chapter, such evaluations should be conducted with sensitivity toward a number of patient characteristics, especially differences in age (Nader, 1997; Ruskin and Talbott, 1996), gender (Wolfe and Kimerling, 1997), ethnicity (Manson, 1997; Marsella et al., 1996), and individual differences in the response to traumatic events (Bowman, 1997).

In our approach, we emphasize from the outset the building of a relationship with patients that can both withstand the inevitable difficulties associated with reporting about traumatic events and lead to the development of a positive alliance with the clinician. This is made possible primarily by an

accepting and empathic stance on the part of the evaluator, one which is characterized by a capacity to tolerate one's own painful reactions while listening to patients' descriptions of horrific events (Pearlman and Saakvitne, 1995) and by a sensitivity to patients' initial capacity to tolerate discussion of their trauma. Clinicians should assess regularly their own reactions to the traumatic material reported by patients, and seek consultation with colleagues who are experienced in dealing with traumatized individuals if those reactions begin to interfere with the work at hand.

Clinical evaluators of traumatized individuals need to be aware of the cycle of violence and victimization and the significant association between a history of trauma, on the one hand, and self-destructive behavior, aggressive behavior, and risk for subsequent victimization on the other (e.g., Breslau and Davis, 1992). Thus, the clinician should always be ready to assess issues regarding patients' safety early on in an evaluation. For example, patients can be asked direct, specific questions about current and historical tendencies toward self-destructive behavior.

TAKING A PSYCHOSOCIAL HISTORY

In the initial encounter with traumatized patients, after establishing the boundaries regarding safety and confidentiality, we begin with a brief discussion about the current presenting problem(s), then take a psychosocial history which is centered on the traumatic event. While taking this overview of a patient's history, we ask about a wide range of trauma across the life span, knowing that the index event may often be only one instance in an extensive history of traumatization. Such information is rarely taken into account in a standard psychosocial history.

Our approach has several advantages. First, patients are given the opportunity to report briefly about their post-traumatic adjustment, but not to the point of becoming overwhelmed prematurely. Second, starting with general developmental topics that are (presumably, although not inevitably) less affect-laden enables patients to experience themselves as competent autobiographers who are capable of taking an active role in the clinical evaluation. Third, the trauma, once it is broached in detail, is situated within the developmental context of the person' s life.

In taking a general psychosocial history, we recommend that the clinician ask questions in chronological order. It is vital to place equal emphasis on both strengths and weaknesses in patients' histories and current functioning, in order to construct a balanced account that has practical utility in the context of treatment. This part of the assessment interview begins with questions about childhood, early relationships with parents and other signif-

icant caregivers, and siblings. Next comes discussion of experiences in school, including academic performance, interpersonal relationships with peers (including intimate ones), and extracurricular activities. Problematic childhood events are then broached, with an emphasis on alcohol and drug use, any antisocial behavior or legal problems, and particularly stressful incidents. The latter may require careful probing about the possibility of abuse, as well as significant losses, during the childhood and adolescent years.

Late adolescence and early adulthood come next, with questions about adjustment to further schooling and work, as well as interpersonal functioning and intimate relationships. Any problematic issues reported to have occurred during childhood should be followed up with specific questions about their development or resolution. This part of the interview should segue naturally into topics relating to patients' current functioning. The major bases to be covered here include psychosocial functioning in the areas of intimate relationships, family relationships (including the extended family), work, and leisure activities.

Once this general contextual information has been gathered, the clinician can then begin narrowing the focus of the assessment toward psychopathology. Patients should be asked about changes they want to make currently, and about factors that may make these changes difficult. Finally, the focus of the assessment is directed toward the target trauma and post-traumatic adjustment.

Caveats in Interviewing

Traumatic events and their psychosocial sequelae are most usefully examined by means of multiple, converging methods of clinical evaluation. However, the clinician is well advised to begin discussion of this material in the context of an interview. In addition, patients should be forewarned that talking about their trauma may well lead to a temporary increase in symptoms, such as intrusive thoughts and nightmares. Again, this material must be handled with caution and with an empathic sensitivity toward patients' capacities to tolerate the memories of the event(s) and associated emotional reactions. Patients may be unable to talk about their trauma, or they may be unable to give complete information, for a variety of reasons, including the forgetting of details, extreme sensitivity to even broaching the topic of trauma, and/or severe numbing, avoidance, and withdrawal. Patients should be informed that they are the sole arbiters regarding what information they divulge and the pace at which they do so. This overt sharing of power and control reinforces the collaborative character of the clinical relationship, and often helps to decrease the anxiety that is almost always associated with direct discussion of traumatic events. Suggested questions for inquiring

about traumatic experiences and post-traumatic adjustment are listed in Table 2.1.

METHODS OF ASSESSMENT

Recognizing the inherent limitations of relying on one source of information, we advocate gathering information by means of different types of clinical instruments. This begins with the use of a trauma-focused clinical interview, as outlined earlier. Once information has been gathered from the general interview, additional methods can be brought to bear in the evaluation of specific aspects of PTSD. These methods include structured diagnostic interviews and various psychometric instruments. Although the use of all of these methods are recommended for the purpose of conducting a comprehensive evaluation of PTSD, limitations of time and resources may make such an assessment impossible. Thus, we end this section of the chapter with suggestions for the diagnostic screening for PTSD.

The definition of PTSD contained in the current nosology used in the United States (American Psychiatric Association, 1994) breaks the disorder down into three sets of symptoms: reexperiencing, avoidance and numbing,

TABLE 2.1. Content Areas to Cover When Interviewing Traumatized Individuals

A. Pretrauma
   1. Developmental (life course) context
   2. Life context at the time of the traumatic event(s)
   3. Events just prior to the trauma
   4. Patient's state of mind just prior to the trauma
B. Trauma
   1. What happened (e.g., sights, sounds, thoughts, feelings, actions, meanings)
   2. What happened afterward (e.g., others' responses)
   3. Unclear or forgotten elements of memories
   4. Feelings about recounting trauma during the interview
C. Posttrauma
   1. PTSD symptoms
   2. Situational cues that trigger reactions
   3. Changes in psychosocial functioning
   4. Changes in belief system about the self and the world
   5. Changes in alcohol and drug use
   6. Treatment history and response
   7. Current environment and resources

and hyperarousal. In addition, symptoms must last for at least one month and must lead to impairment in social or occupational functioning. According to Criterion A, exposure to a traumatic event is defined as the experience (direct or indirect) of an event (or events) that constitutes a threat to the life or limb of self or other, accompanied by extreme fear, horror, or helplessness. A number of instruments are available for assessing such events (see reviews by Briere, 1997; Norris and Riad, 1997). For example, the Evaluation of Lifetime Stressors Questionnaire and Interview (Krinsley et al., 1994) is a comprehensive protocol for assessing a wide range of stressful events across the life span. Another example is the recent Traumatic Life Events Questionnaire (TLEQ) (Kubany, 1995), which is also designed to be consistent with the current DSM-based definition of a Criterion A event. The TLEQ makes possible the subjective evaluation of seventeen traumatic events and associated emotional responses within two and twelve months of the assessment. In addition, instruments such as the Clinician-Administered PTSD Scale (CAPS-DX; Blake et al., 1996) and the Posttraumatic Stress Diagnostic Scale (PDS; Foa et al., 1993) contain checklists to assess the occurrence of Criterion A (traumatic) events.

In the DSM-IV, criterion sets B, C, and D contain the specific symptoms of PTSD, grouped according to their designation as symptoms of reexperiencing (B), avoidance and numbing (C), and hyperarousal (D). Although reexperiencing, avoidance and numbing, and hyperarousal must be present in order to make a diagnosis of PTSD, the specific symptoms required within each criterion set are variable in number, ranging from one (B) to three (C). Since only a subset of symptoms is required from each cluster, and there are no necessary or sufficient symptoms within each cluster, there are quite a few potential combinations of symptoms that may qualify a patient for a diagnosis of PTSD. In other words, patients with a diagnosis of PTSD may present very differently, making an idiographic analysis of patients' constellation of symptoms essential in terms of their frequency of occurrence, intensity of experience, and degree of functional impairment.

A number of methods are available for the assessment of PTSD symptoms. These include structured clinical interviews, self-report scales dedicated to PTSD, and broad spectrum instruments that contain PTSD subscales. At least six structured interviews are available for the assessment of PTSD (see reviews by Briere, 1997; Weathers and Keane, 1998; Weiss, 1997). We recommend the use of the Clinician-Administered PTSD Scale for the DSM-IV (CAPS-DX; Blake et al., 1996). The CAPS-DX allows the clinician to evaluate up to three Criterion A events, as well as each of the seventeen symptoms of PTSD contained in the DSM-IV and five additional symptoms commonly associated with PTSD. Each symptom and associated feature can be characterized on the dimensions of time (current, lifetime), frequency, and intensity. Another example of this kind of assessment instru-

ment is the Structured Interview for PTSD (Davidson, Smith, and Kudler, 1989). Other PTSD interviews include the PTSD module of the Structured Clinical Interview for DSM-IV (First et al., 1996), the Structured Interview for DSM III-R/PTSD (Spitzer et al., 1990), and the interview version of the PTSD Symptom Scale (PSS-I Foa et al., 1993).

In addition to structured interviews, more than a dozen paper-and-pencil measures have been validated for the assessment of PTSD. These can be divided into those that correspond directly to the DSM diagnostic criteria for PTSD, those designed specifically to assess PTSD but that do not correspond exactly to the DSM criteria, and those empirically derived from existing questionnaires (Weathers and Keane, 1998). An example of DSM-correspondent measures is the PTSD checklist (PCL) (Weathers et al., 1993). The PCL consists of seventeen items that correspond to the seventeen PTSD symptoms in the DSM-IV. Each item is rated on a five-point scale, indicating the severity of a symptom over the past month. Similar measures include the PTSD Symptom Scale–Self-Report (PSS-SR) (Foa et al., 1993), which is the paper and-pencil version of the PSS-I, and the recently published Posttraumatic Stress Diagnostic Scale (PDS) (Davidson, Smith, and Kudler, 1989). The PDS is unique among (paper-and-pencil, self-report) measures of PTSD in that it assesses all six (A-F) of the DSM-IV diagnostic criteria for PTSD.

Some of the most widely used measures of PTSD do not conform strictly to the criteria contained in the DSM. Among these are the Mississippi Scale for Combat-Related PTSD (Keane, 1988) and the Impact of Event Scale (IES) (Horowitz, Wilner, and Alvarez, 1979). The Mississippi Scale consists of thirty-five items, rated on a five-point scale, that tap the DSM-III PTSD criteria and a variety of associated features. The civilian version of the Mississippi Scale includes four additional items intended to ensure adequate coverage of DSM-III-R criteria. Also, items on the original Mississippi Scale referring to the military were rephrased for the civilian version. The original IES consisted of fifteen items, with seven items assessing intrusion symptoms and eight items assessing avoidance symptoms. Respondents specify a traumatic event, then rate the frequency of each symptom over the past week, using a four-point scale. The IES was recently updated to bring it more into line with DSM-IV PTSD criteria (Weiss and Marmar, 1997). Seven items were added, primarily tapping hyperarousal symptoms, and the response format was changed to a five-point scale, indicating degree of distress caused by each symptom.

Another instrument in this category is the Penn Inventory (Hammarberg, 1992), a twenty-six–item scale that assesses many, but not all, of the DSM PTSD criteria, as well as a number of associated problems. Similar to the Beck Depression Inventory (BDI-I) (Beck, Steer, and Brown, 1996), items

on the Penn consist of four statements graded to reflect increasing symptom severity.

The final category of self-report PTSD measures are PTSD scales derived from existing instruments such as the MMPI and the Symptom Checklist-90-R (SCL-90-R). The most widely used of these is the PK scale of the MMPI and MMPI-2 (Keane, Malloy, and Fairbank, 1984; Lyons and Keane, 1992). The original PK consists of forty-nine MMPI items found to distinguish between combat veterans with and without PTSD. Three repeated items were dropped when the MMPI-2 was published. The PK scale can be used effectively when administered either in the context of the full MMPI-2 or as a stand-alone instrument (Herman et al., 1996; Lyons and Scotti, 1994). Other examples are the PTSD scales of the SCL-90-R. The Crime-Related PTSD Scale (CR-PTSD) (Saunders, Arrate, and Kilpatrick, 1990) consists of twenty-eight SCL-90-R items that discriminate female crime victims with and without PTSD. The War-Zone-Related PTSD Scale (WZ-PTSD) (Weathers et al., 1996) consists of twenty-five SCL-90-R items that discriminate male combat veterans with and without PTSD. Interestingly, these two scales, derived through similar methods but on very different trauma populations, share only eleven items. Subscales have also been developed from some standard psychometric instruments that are typically used to assess a broad range of psychopathological conditions. The PK Scale (Lyons and Keane, 1992) from the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Graham, 1993) is one example.

Other instruments are available for the evaluation of specific conditions that are commonly associated with PTSD. The clinician interested in diagnosing other Axis I disorders based on the criteria contained in the DSM-IV can employ the *Structured Clinical Interview for the DSM-IV (Patient Edition)* (SCID-IIP) (First et al., 1996). This may be particularly helpful in identifying depression, substance use disorders, and anxiety disorders that often occur with PTSD. Also useful in evaluating the severity of depression and anxiety are the Beck Depression Inventory (BDI) (Beck, Steer, and Brown, 1996) and the Beck Anxiety Inventory (BAI) (Beck et al., 1988), both of which are brief, self-report scales. Certain disorders of personality, especially borderline personality disorder, are also commonly seen in patients with PTSD. These can be evaluated by means of the *Structured Clinical Interview for the DSM-III-R Axis II* (SCID-II; Spitzer et al., 1990). More broad-based instruments for assessing personality characteristics are also available and some (e.g., MMPI-2) have the added benefit of containing imbedded scales for PTSD.

Although not yet widely used for this purpose, the evaluation of some symptoms of PTSD, especially physiological reactivity and exaggerated startle response, are evaluated most directly by means of psychophysiological measurement (see review by Orr and Kaloupek, 1997). Physiologi-

cal reactivity can be assessed with measurements of heart rate, skin conductance, and blood pressure in response to a trauma-related "challenge" (e.g., script-driven imagery of an index trauma).

A Brief Screening

The comprehensive assessment of PTSD that we recommend clearly requires considerable resources of personnel and time. Certainly the average clinician working within the current confines of most managed care systems is unlikely to be given the amount of time necessary to administer a battery of structured clinical interviews and psychometric instruments. Although a comprehensive assessment is impossible to perform within a single session, the busy clinician can still conduct a screening for the presence of PTSD within such limits. In this context, we suggest a brief clinical interview combined with either the PCL-C or the PSS-SR. We suggest the use of a more thorough assessment tool (the CAPS, for example) at the beginning of therapy as a means of identifying and clarifying further the targets for intervention.

USING ASSESSMENT RESULTS IN MAKING CLINICAL RECOMMENDATIONS

The final section of this chapter is devoted to the link between the results of a comprehensive assessment of PTSD and the clinician's recommendations for treatment. Whichever methods the clinician uses to perform the assessment, the results must be brought together into a coherent whole that can be used to guide deliberation about specific forms of treatment or clinical management. Such recommendations are informed primarily by two factors. One is the current condition of the patient with PTSD. Flack and colleagues (Flack, Litz, and Keane, 1998; Keane, 1995) recommend tailoring psychotherapeutic treatment to the current presentation of the patient. For example, many patients will present for evaluation and treatment during periods of acute crisis. Clearly, acutely and severely disturbed patients are not good candidates for therapy that is focused on their memories of trauma and associated emotions. Rather, they should be referred for supportive work that is aimed at behavioral and emotional stabilization. Medications may prove helpful in this regard, and those designed for the treatment of anxiety and depression are often favored for patients with PTSD (Friedman, 1991). Once stabilized, such patients may benefit from therapeutic approaches that include stress management, psychoeducation about PTSD, trauma focus, and aftercare.

An important goal in the assessment of PTSD is to prioritize targets for change since experiences of trauma and subsequent posttraumatic pathology are associated with comorbid psychiatric conditions and numerous problems in living (see Keane and Kaloupek, 1998). Comprehensive treatments of PTSD usually entail multiple techniques and strategies that target specific clusters of symptoms and comorbid conditions; reexperiencing symptoms may be treated with exposure therapy of one type or another; symptoms of avoidance may be treated by gradually encouraging the person to increase the range of their interpersonal contacts and activities, coupled with the application of coping skills; hyperarousal symptoms can be addressed by training in stress management.

Exposure Treatments

The emotional processing of trauma-related memories, including various types of direct therapeutic exposure, is usually considered central to the treatment of posttraumatic pathology (Fairbank and Brown, 1987; Flack, Litz, and Keane, 1998; Keane, Zimering, and Caddell, 1985; Keane et al., 1989). Direct therapeutic exposure has the most empirical support in the treatment outcome literature (Solomon, Gerrity, and Muff, 1992). Exposure treatments, however, require considerable resources on the part of both patients and therapists. Deciding whether exposure treatment is indicated for a given combination of patient and therapist is a critical task in the assessment of PTSD.

Several conditions must be met before a therapist should recommend exposure treatments. First, patients must be able to meet the boundary conditions of the technique, such as the ability to form images about traumatic events (see Boudewyns and Shipley, 1980; Levis, 1980). For example, candidates for exposure therapies should report reexperiencing symptoms and exhibit some level of anxious arousal in response to reminders of their trauma. Furthermore, they should be able to follow the therapist's instructions and to imagine various stimuli clearly. A second requirement of exposure techniques is patients' capacities to tolerate the intense levels of arousal associated with the treatment, as well as the increase in PTSD symptoms that often occurs at the beginning of treatment.

The therapist should be especially observant about the potential for therapy dropout when making a decision about recommending exposure treatment. Critical to this decision is patients' abilities to tolerate the intense levels of arousal generated during exposure therapies. Thus, patients should be in relatively good health (moderate to severe heart conditions, for example, are rule-out conditions), have a stable living environment (or some consistent social supports), and not be abusing drugs or alcohol. These decision rules regarding the use of exposure therapies are conventions derived from

clinical experience (Litz et al., 1990); specific conditions for positive responses to such treatments have not yet been demonstrated empirically.

SUMMARY

In this chapter, we outlined one approach to the comprehensive assessment of PTSD in adults. The approach is one in which information about exposure to traumatic events and their psychosocial consequences is made meaningful by being embedded within the development of the individual patient across his or her life span. Numerous techniques are available for the elicitation of this information, and recommendations for treatment are based on the current needs of the patient and phase of disorder.

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